FIRST 5 CALIFORNIA
501 J Street, Suite 530, Sacramento, CA 95814
Phone: 916-323-0056 Fax: 916-323-0069

Health Access for All

Semi-annual Premium REIMBURSEMENT INVOICE

Program Enrollees (0-5 years of age)

County Commission

County _____
Executive Director _____
Address _____
City/St./Zip _____
Phone _____

Project Term: _____
Reporting Period for
Fiscal Year 200__ - 200__
Check Appropriate Reporting Period:
☐ July - December **(Due date is January 30)**
☐ January - June **(Due date is July 30)**

	CCFC Share Monthly Premium Cost	July Members	Aug Members	Sep Members	Oct Members	Nov Members	Dec Members	Total
Number of Members (0-5)								
CCFC Share 20% of Monthly Premium Cost (0-5 years of age)								

Actual Health Insurance Annual Premium Cost per Member	
To calculate the monthly reimbursement amount per member	
Monthly Cost per Member	
CCFC Share is 20% of the Monthly Premium Cost *	

* Per the First 5 California Health Access for All RFF, the State's share will not exceed 20% of the actual annual health premium cost or 20% of $1,100, whichever is less.

First 5 California Health Access Funds

Annual State Matching Fund Allocation to the County	
Rollover Amount from Previous FY	
Subtotal	
First Semi-annual Invoice Amount (Current FY)	
Second Semi-annual Invoice Amount (Current FY)	
Remaining Balance	

Terms and Conditions

☐ Attached is the Semi-annual Rembursement Report for the above time period required to receive reimbursement.

Total Local Match toward the Premium Cost for Reporting Period

Source	Amount
1	
2	
3	
4	
Total	

I certify that all the information provided above and in the attached reports are true and accurate.

First 5 County Executive Director or
Authorized Commission Representative

_____ Signature _____ Date

First 5 CCFC Use Only

Program Management Division

_____ Signature _____ Date

_____ Signature _____ Date

Administrative Services

_____ Signature _____ Date